Meaningful Use's Workgroup Subgroup #4
Improving Population and Public Health
Transcript
July 13, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, subgroup #4, Improving Population and Public Health. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I'll now take roll. Art Davidson?

Arthur Davidson – Denver Public Health Department – Director

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Art. Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Charlene. Amy Zimmerman? Marty Fattig?

Marty Fattig – Nemaha County Hospital (NCHNET)

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Marty. Yael Harris?

Yael Harris – Human Resources and Services Administration

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Yael. George Hripcsak? I know he was on the line earlier; he might just be on mute. Are there any workgroup members on the line? Okay, is there any staff on the line?

James Daniel – Office of the National Coordinator – Public Health Coordinator

James Daniel.

MacKenzie Robertson – Office of the National Coordinator

Thanks James. Okay Art, I'll turn it back over to you.

Arthur Davidson – Denver Public Health Department – Director

Okay. Thank you all for joining this morning. We're getting close to the time when we can present, I think it's next Wednesday, to the Meaningful Use Workgroup. Have I got that right, well, Michelle will know for sure, I'll pull up my calendar, but I'm pretty sure we're having a meeting of the workgroup next Wednesday.

MacKenzie Robertson – Office of the National Coordinator

You're right, this is MacKenzie. It's July 18, I have 9 a.m.

Arthur Davidson – Denver Public Health Department – Director

Right. Okay. So, I've sent out, and I think Michelle has now forwarded to you, the latest draft of a planning document that's dated 12-7-13 is the end of the file name. And, I received comments from Yael, written comments, and the comments that we had by phone last time we spoke, I've tried to incorporate all those. And I had as well, some conversations with the people from the CDC, mostly with Seth Foldy, regarding how we might structure this. So, the version that you have here has been reviewed by our group, and by Seth, and maybe a few people at CDC, and this is the latest version of what we've been working on. I put at the top of this, just for context sake, the few items that Paul had mentioned during a Meaningful Use Workgroup call. And then I believe it was either Michelle or MacKenzie that sent these out and I just put them at the top of the document, so, we may want to be thinking about these as we run through, see if we've touched on these impact criteria that Paul had suggested, and then the attributes of a good objective or measure.

To get us going, I did put down these four general comments. I don't know if anybody has had a chance to read the document or look at it, I'm sorry it came so late. But, we can run through today, and I thought that at the beginning of our presentation next week, we might bring up these four points. There may be others that come up in the discussion, but the first item is greater value and public health impact by increasing the number of public health program areas that are being affected by or benefit from these measures that we're working on. And then the next one is leveraging the other EHR functionalities that we anticipate from, for instance, transitions of care or CDS, that might be bidirectional health information exchange, consolidated CDA messaging and knowledge-based systems.

And then, the readiness…this is a concern that we all expressed but the Yael kind of pointed it out several times in her read through this and I thought we'd just kind of put that out there at the front. I think the Yael was suggesting that maybe we could encourage ONC and CDC to somehow take some pro-active role around this. I don't know that that's something we can do, but we could at least make mention of our concern about the readiness. And then the last one is just an observation that some of the things that we deal with here, in the next eight items that we'll go through, relate to patient safety priorities. That's not necessarily in our own…in the fourth workgroup, but maybe related to the first workgroup, such as healthcare associated infections (HAI) and it says here, vaccine, adverse events, it should just say, adverse events and forget about the reporting systems. I've modified that so, it just says healthcare associated infection and adverse events. I've made a change even from the document I sent out to Michelle, which she forwarded to you. Are there any comments about those general observations that our subgroup would make in the presentation?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Art, this is Charlene. I think that's great because what I've been trying to think about, even in our subgroup are kind of what are the assumptions that I make, like the bidirectional platform is in place, most transitions of care are occurring, so, I think it's really important that we start to surface that in terms of how we think about Stage 3. So, I support that. The other comment I might make is, there needs…this is where I struggle a little bit and we kind of talk about it, are lines between the different areas blurring. Like within the context of managing a population of diabetic patients or patients at risk for readmission, there's functionality for managing those cohorts of population; so, I don't know if the word public health in that first statement should be public and population health. I know you've got population based outcomes in your later statement, so, I just wouldn't want to…like I want to transition some objectives over, so, I think we just have to be careful that it's broader, if you will, than public health.

Arthur Davidson – Denver Public Health Department – Director

Right, no, I…that's a good suggestion, I'm sorry I didn't…I just added it,

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, that's fine…moving it and putting your assumptions down, the barriers, the assumptions, the barriers, right, are really important. You have given us barriers there; I can start to highlight them at a policy level to get there. Thank you.

Arthur Davidson – Denver Public Health Department – Director

So, are there any specific barriers that you think we should be pointing at…I mean, we have the one there, the third one, are there other barriers?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think, well implied in there I thought was the state variation, and again that's a huge deal for the vendor community, is the variation among the states. So again, I think you implied that in there, but I don't know if you want to call that out.

Arthur Davidson – Denver Public Health Department – Director

You mean variation in capacity.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Variation in capacity to handle different standards, different approaches, now we write a different interface for every state, some states are doing it across multiple state boundaries, like, every variation we could…you know…there's opportunities for parsimonious synergy here I think that would help everybody. Some are ahead, some are behind; some are more local, some are more state.

Arthur Davidson – Denver Public Health Department – Director

Any other comments? Thank you Charlene, those are important I think. So maybe what I'm hearing is that rather than just making this general comments, we might break these up into assumptions and barriers, is that right?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Or just general…yeah. I mean I'm fine with as they read, but as I thought them through, that's kind of how you talk to them basically.

Arthur Davidson – Denver Public Health Department – Director

Right. Right. So maybe I can reorganize that over the next several days. Good, thank you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

You're welcome.

Arthur Davidson – Denver Public Health Department – Director

Any other comments? Good. Well, let's go ahead and work our way through this document. There are these eight sections that we'll hopefully get to present, or maybe we'll have less or more by the end of this meeting, but these are the ones that have surfaced over the last couple of months in our work. So, let's proceed to the first one. This is one that has been, has probably had the most scrutiny from the immunization program at the CDC. When I sent this off to Seth, maybe three weeks ago, this is one that he immediately sent on to that program and so the wording here is about as close to what that program would like, based on their ability to review this. Many of the programs for the other areas did not get a chance to comment directly. So, this new objective…the first thing is the current objective is unchanged, as it would be in Stage 2, is successful ongoing immunization data submission to a registry or an IIS. The new objective is the capability to receive and review a patient's immunization history supplied by a registry or IIS and the healthcare professional's ability to incorporate such historical information into the immunization record of the EHR. So, this is a step forward, and certainly going to be harder for the EHR vendors to absorb this data from outside. We're not saying this needs to happen on 100%, this is a threshold that was set…I mean, if you started to do this in some patients, we'd be making significant progress. So, we set this threshold at about 30. I think there was some confusion in the last version of this that Yael pointed out that, it's what 30% is this, and it's for those who received an immunization during that reporting period. Any questions or comments?

Amy Zimmerman – Rhode Island Department of Health & Human Services

All right, this is Amy and I have joined, sorry I joined so late.

Arthur Davidson – Denver Public Health Department – Director

Okay, thank you Amy.

Amy Zimmerman – Rhode Island Department of Health & Human Services

On the exclusion, is it just…so it's where there's either no immunizations administered or jurisdictions where the registry or the information system cannot provide an immunization history, is that…do we mean just an electronic history there?

Arthur Davidson – Denver Public Health Department – Director

That's correct. We're going to provide…yes.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, I don't know if that makes a difference or not or if we need to spell it out.

Arthur Davidson – Denver Public Health Department – Director

Yeah, I just added the word…

Amy Zimmerman – Rhode Island Department of Health & Human Services

…people's immunization history on paper, we still want them to somehow get it into their system, right. So, I don't know if we need to spell that out here or not.

Arthur Davidson – Denver Public Health Department – Director

No, I don't think that…I think what we're saying here is that the immunization history should be coming back from the registry electronically.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right. So this is really for…it's for immunization information systems that can provide electronic immunization history.

Arthur Davidson – Denver Public Health Department – Director

That's correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I think we just want to put the word electronic in that.

Arthur Davidson – Denver Public Health Department – Director

I did. Thank you. Thank you for the suggestion. Good. Any other comments about that? Okay…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, this is Charlene. One of…this is a little bit, it relates to the other Meaningful Use call we had when we started to talk about reconciliation. When you start to think of this as bidirectional, is there a reconciliation step here within the EHR when the data comes back?

Arthur Davidson – Denver Public Health Department – Director

Ummm.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So Charlene, this is Amy. I think it depends how…I would say that it would…there potentially could be, because you don't want duplicates. It depends if you're getting a whole…it depends how the immunization registry, I would think, is set up. If they're sending you everything they have on that individual back…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Oh, that'd kill you, right?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm sorry.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, then you would have to de-dup those. If they're receiving something that the immunization registry is sort of comparing and just giving you new or updated…so, I don't know how…I think that's an excellent point, I don't know how that works, but I think there…I think it's a little bit more of a...

(Indiscernible)

Amy Zimmerman – Rhode Island Department of Health & Human Services

…for immunization registries to be able to sort of, if you sent them something, like if you're sending a record of what you have, they do a compare and contrast and send you back only what you don't have.

James Daniel – Office of the National Coordinator – Public Health Coordinator

This is Jim and I just wanted to ask Art if he received that business process analysis from PHII? I think that addresses a lot of the questions that are coming up, and they defined a standard way that they….happen.

Arthur Davidson – Denver Public Health Department – Director

Yeah, I think….

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...the reconciliation process Jim, is that what you mean?

James Daniel – Office of the National Coordinator – Public Health Coordinator

Yeah, they actually define the entire bidirectional exchange, because there are several sticky points along the way. There's de-duplication of the person in the registry de-duplication of the shots, what they send back. And they actually, they go into quite a bit of detail for all of these, and they're trying to promote it as a standard way that all immunization registries would do bidirectional exchange.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The reason I brought the point up was that Paul kind of challenged us to say, what should kind of be the roadmap for the transition of care, and as we started to look at the data types, it's meds, allergies, but immunization, because it's structured, starts to come into the picture there. So, I don't know where it sits, but, it's relevant…like these lines are blurring, it could kind of go on my roadmap, if you will, as the data starts to come in. So, I don't know if we want to put it here, but I just wanted to surface it as a thought as we continue through this process. That's fitting into the workflow and all is going to be a challenge, but I see that coming in Stage 3 as more this reconciliation tool.

Arthur Davidson – Denver Public Health Department – Director

Right. So I think one of the things that was pretty clear in this discussion with CDC, and this may be influencing our answer to your question Charlene, is that the immunization program is far along in an HL7 message that is not CDA based.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Arthur Davidson – Denver Public Health Department – Director

And while we want to be in line with the transitions of care documents, and take advantage of that technology, this is probably an area that if we made a recommendation where it was entirely lined up with transition of care, we'd get a lot of push-back from ARRA and all the registries, because they've invested so heavily in this…in a different method. So, I don't know if it's appropriate for us to, at this time, try to merge them. It's not to say that immunizations should not be part of a CDA, it's just that…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And I wasn't even…because…I wasn't even going there per se, but...because it's a logical…checking...I don't know, we could probably think of all sorts of use cases where it's appropriate or not appropriate, but…

Arthur Davidson – Denver Public health Department – Director

So, I think Jim brings up a good point here, is that maybe should we reference that document…this is probably a little bit too detailed for a policy recommendation, but maybe we could make a…

James Daniel – Office of the National Coordinator – Public Health Coordinator

I was just recommending it for this group to review so they could understand some of what will be there in the standard.

Arthur Davidson – Denver Public Health Department – Director

Okay, and I think I got…I know I looked at that before. You sent that to us, right Jim.

James Daniel – Office of the National Coordinator – Public Health Coordinator

I can't remember if I sent it or if Bill sent it, I'm sorry.

Arthur Davidson – Denver Public Health Department – Director

Okay, well, we'll review that. I think it wasn't ready yet published, it's still in draft form, is that right?

James Daniel – Office of the National Coordinator – Public Health Coordinator

Yeah, but I think Joe was willing to share the version that they had just with you guys. I thought he had sent…I think it was him that sent it.

Arthur Davidson – Denver Public Health Department – Director

Okay, we'll follow up with Joe. Thank you. So any more about this new one? Do you feel comfortable Amy with the way that this is worded now?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yes.

Arthur Davidson – Denver Public Health Department – Director

I mean, is it ambiguous that we need to get down to that level of detail.

Amy Zimmerman – Rhode Island Department of Health & Human Services

No, I mean, I don't think we need to, I mean, we've never put…the objective doesn't usually have the standard in there, so, I think we're fine and I think the biggest issue is, how ready by Stage 3 are state and immunization registries to be able to do the bidirectional. There all trying to move there, so, I think that you've got the exclusion in there, we can't hold the doc hostage for something that registries can't do. So, I think we're fine.

Arthur Davidson – Denver Public Health Department – Director

Okay. Let's move on to the next one in category one, which is the capability to receive or generate patient-specific recommended immunizations, based on the patients total historical immunization record, maintained by the EHR. And this could be a clinical decision support measure, but I didn't want to directly say that this must be a clinical decision support measure but, I think, something clinical quality measure group might consider. So, that's the way it's worded here. I think Yael said, in one of her comments, that we needed to give more examples of how this would be a clinical decision support, and I just wanted to raise the idea, not just say, this is a clinical decision support measure.

James Daniel – Office of the National Coordinator – Public Health Coordinator

And Art, is this about the EHR doing this or about accessing the recommendation from the registry?

Arthur Davidson – Denver Public Health Department – Director

I'm sorry, would you say that one more time Jim?

James Daniel – Office of the National Coordinator – Public Health Coordinator

Was this about the EHR having the capacity for that clinical decision support or accepting the recommendations from the immunization registry?

Arthur Davidson – Denver Public Health Department – Director

So it says that it's either of those. So, it said that the…let me see, the certification criteria was…

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well the language that we have here Art is to receive or generate, so, we spent a lot of discussion about this in terms of some places they may. I mean, and Charlene, I think you weighed on this last time. We really don't want to have to have every EHR develop its own algorithm based on local and state…with the variability in the different states, I know I've raised this, different states, especially like universal vaccine, may have different slight products which might have slight different variations in catch-up schedules, blah, blah, blah, blah, blah. So…

Arthur Davidson – Denver Public Health Department – Director

So, the idea is that ACIP may create a schedule, and that schedule should be available for the EHR to consume. But there may be, as you say Amy, some specific reasons why you are not following that schedule. For instance, when there are vaccine shortages, that recommendation might be changed. There may be a recommendation based on a current outbreak, that someone may make a recommendation that's different. So, we…I spoke with the immunization people in my own organization and they said, don't make us use a national recommendation if there's a reason locally for us to not follow that. And that's a decision that each site should use, they should just be able to make a recommendation and whether they receive it or generate it, that's the option.

James Daniel – Office of the National Coordinator – Public Health Coordinator

So, I'm not sure exactly how that has to be recommended, the recommendation.

Arthur Davidson – Denver Public Health Department – Director

That's not the way the CDC recommended it, but the CDC believes that they have the truth, and I'm…

James Daniel – Office of the National Coordinator – Public Health Coordinator

No, the CDC believes that each state or each immunization registry should produce a recommendation for the providers using that registry. And that takes into account the local changes and shortages and things like that.

Arthur Davidson – Denver Public Health Department – Director

They…our registry does not know what our local shortages are.

James Daniel – Office of the National Coordinator – Public Health Coordinator

Does your registry produce recommendations?

Arthur Davidson – Denver Public Health Department – Director

Our registry produces recommendations, yes.

James Daniel – Office of the National Coordinator – Public Health Coordinator

Okay. But, I think that's what the CDC recommendation is, is that the clinical decision support comes from the local immunization registry, not from the CDC or from an EHR.

Arthur Davidson – Denver Public Health Department – Director

But that's okay; I think that ACIP could produce the floor. Our local and state registry could then say, here's our modifications for the state and then on top of that, there could be very local recommendations based on the conditions that may exist in that institution or practice.

James Daniel – Office of the National Coordinator – Public Health Coordinator

And it's the actual individual recommendation that would be coming back it's not the rules.

Arthur Davidson – Denver Public Health Department – Director

Right, it's the individual, patient-specific recommendation, that's correct.

James Daniel – Public Health Coordinator – Office of the National Coordinator

I have to drop off now, I'm sorry Art. Thank you.

Arthur Davidson – Denver Public Health Department – Director

Okay, thank you Jim. Have a good trip.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So Art, one of the…I think one of the challenges with the way this particular objective may be worded, and actually, when I look back at the other one, these are objectives for what the physicians have to do, although it implies what the EHR has to do. As opposed to, writing an objective of what the EHR has to do, right.

Arthur Davidson – Denver Public Health Department – Director

Well, these are written from the perspective of the EHR, are they not? You think they're not.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well, but aren't most of the meaning…I mean, don't we want this to be what the functionality the physicians have to use versus what the EHR has to do?

Arthur Davidson – Denver Public Health Department – Director

Well, we paralleled the way it's worded in the Stage 2 NPRM.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

Arthur Davidson – Denver Public Health Department – Director

And maybe I haven't followed that.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But Amy, I think you're right. It's like…

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm sort of struggling because for instance, and I'm thinking about what Charlene said before and just knowing how…knowing the variation in vendors, are we basically saying every vendor has to be able to have the capacity to generate a recommendation based on ACIP guidelines, even if they're going to use it from…even if they're also then going to have to…are they going to have to do that and then also be able to accept it from the state or local immunization registry? Like I know in our state we would want that, I believe, and I haven't spoken to them lately, but, it's always been we would much rather them use the recommendations that our immunization registry provides. Again, we're a universal vaccine state, we don't…it's different than…may be different than in other states. But, if that's what Jim was saying CDC is saying…I mean, I understand we need to give some flexibility, but I'm also thinking from the vendor point of view…if they have to…if we don't say they have to do it at least minimally according to ACIP, then the vendor has to go…you know, feel they have to do it for Rhode Island versus New York versus California, versus Texas…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, you'll get a…

Amy Zimmerman – Rhode Island Department of Health & Human Services

…that's a problem I would imagine.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, you're going to get a horrific swirl-out there, it'll just swirl.

Arthur Davidson – Denver Public Health Department – Director

Well, I don't think we want to say what they need to consume, I think the idea that they're able to either receive the recommendations from the Rhode Island immunization system or they could do it if a local site wants to program all this, that's their prerogative.

Amy Zimmerman – Rhode Island Department of Health & Human Services Affairs

But then what are we measuring for certified patient criteria for this is what I'm trying to say. What's the minimum that the vendors…they have to prove…each EHR vendor has to prove that they can accept from…they can accept whatever recommendation from every state and then they don't have to program it in, or they have to prove that they can…I'm trying to reconcile in my mind here how this would work.

Arthur Davidson – Denver Public Health Department – Director

Actually, I see that the measure is still old and we need to change that. So, I don't know that we want to say this is a clinical decision support intervention. So, the need to implement a…and it's not a quality measure, because then that kind of gets…it automatically says that we're in the quality measure stuff.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, what we did when we were struggling with this one under patient preferences, we put in an attribute of the clinical decision support piece that it could…and this isn't going to help vendors Amy, but what we did is, like if you're going to use clinical decision support, it needs to respect patient preferences. And the other attribute we suggested thinking…I mean, this could be an attribute of clinical decision support if we wanted to go that way...you know, rather than being so specific at this point.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And it could be that what the…what was that other word you just said, it's not on the page, I didn't write it down. The highest-level recommendation…

Amy Zimmerman – Rhode Island Department of Health & Human Services

You mean the floor.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

No, what did you say, it begins with "a"…

Amy Zimmerman – Rhode Island Department of Health & Human Services

Oh, you mean the ACIP recommendations.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And is that…I don't think we want to say where they get them from, so, do we want to make, we would like there to be a clinical decision support attribute added that considers ACIP recommendations or is there some other floor we could put in place? Because then we'll let the industry start to deal with the fact it's multiple states and they need to get aligned and all that kind of stuff.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

You guys had better determine what the concept should be, but...

Amy Zimmerman – Rhode Island Department of Health & Human Services

I get the…

Arthur Davidson – Denver Public Health Department – Director

Go ahead Amy.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And right now practice management systems do it; this is done all over the place. This kind of functionality.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You mean the functionality of making the recommendation on immunizations.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I mean, I know we've wrestled with this on every call because it's a tricky one.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It is tricky.

Amy Zimmerman – Rhode Island Department of Health & Human Services

If it weren't tricky, we would have solved this earlier.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But, maybe it's just more the consideration that if we start to bucket it under a clinical decision support attribute, it starts to show up on certification, right. And then we don't get as prescriptive in terms of trying to solve all these problems.

Arthur Davidson – Denver Public Health Department – Director

So let me ask, because I tried to remove this clinical decision support wording in the first…in the objective and, Yael, you had some comments about whether this should be clinical decision support and whether we've given enough examples. What were you trying to convey there, I wasn't quite sure.

Yael Harris – Human Resources and Services Administration

Well, I mean I'm thinking if we do a clinical decision support, we need to be explicit about what we mean. So for example, as the doctors entering the date of birth of the child, or I guess date of birth, entering that this is a three-month visit for example or a six month visit. A pop-up would come up stating explicitly, this is…recommends this immunization at this time. So, if we're saying immunizations, it should be a clinical decision support rule that explicitly comes out at the right time so the doctor can act on it. And, I'm not a clinician, but I'm thinking if we are saying CDS, we should be...give an example, we don't have to be explicit about every single example, but give an example.

Arthur Davidson – Denver Public Health Department – Director

Okay, so I thought that this would be…I mean, it could be at that level. I think, and I don't know Amy may have some comment about that. I thought this would be more along the lines of, I'm thinking about giving this kid some shots and then I'm going to check to see what the clinical decision support rule suggests versus here's a three month old and now I'm going to run this rule because I know it's a three month old. Which is a more complex version of the clinical decision support rule.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, since I don't…I'm not a practitioner or anything, I think…actually, my guess would be that, unless we have any providers on the phone that give immunizations, my guess is that some of this is done anticipatory of a well-child visit, or if you're in for a sick visit and I guess I need to catch you up or something. But, I think…my point here is that I think the workflows may vary in terms of when and how individuals check what immunizations they need to give. But typically they're given at well child visits. And, even if I think about my own experience with my own kids, going into a pediatric office, they kind of have already queued up what they need to give. But I had my son in there the other day, he's going on to college, and I had to…they were pulling it up and looking in their EHR at the time when we were discussing what he needed for catch-up. And they were having to go back and forth and look at the schedule and this, that and the other thing and figure it out. So I think that…my point here is that I think the workflow around using it, I think is going to be variable. I mean if you program it to be used as clinical decision support will that negate the ability to look at it in some other way, I don't know.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That is like the assumption, I mean, if you build in the capability to use…and most vendors will try and use some sort of a reference to be able to generate their immunization logic, right, whether it's in their system or however they're gathering it from. And again, they'll send out reminders with visits and all this, so a lot of that stuff I think is in place, so I do think a lot of it's there already, and maybe it's what problem we're trying to solve here may be the issue.

Arthur Davidson – Denver Public Health Department – Director

I don't know that we need to get into the workflow stuff, I think it's just the idea that there is a tool that has a way to make a recommend function. And, we just want that part to work, that it would incorporate the data that's in the EHR and any other immunizations that are available from the registry.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, our going back and reading the words and trying to think about how do we move this forward and trying to be literal, but not too literal, we have the capability to receive or generate. Maybe we need to put something in that sort of as applicable by state policy or something. In other words, I would hate to have vendors be able to…if in Rhode Island we want everyone using the registries recommendations, but vendors are…say, we didn't build in that capability, we built in our own algorithm. And the state's saying, well that doesn't really work for us, that's not going to be very helpful for you. I mean, that's where I think we're getting into the issue here, and I wonder if there's a way to say…because you've got an "or," right…so…

Arthur Davidson – Denver Public Health Department – Director

Right, because I don't think that we have to say…I don't think that we can say that you must use the state recommendations, a local site could make up its own and that would be appropriate.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right.

Arthur Davidson – Denver Public Health Department – Director

I mean, that's why…the EHR should be able to make a recommendation. How it got to that point is something I don't think we can dictate, it must come from ACIP, it must come from the state. It could be that a provider really cares enough that they invest all this time and effort to maintain their own logic. I think that's wasteful, but that's not for us to determine.

Yael Harris – Human Resources and Services Administration

But I'm concerned if we're not giving guidance…this is Yael…if we're not giving guidance on it, how do we know it's even going to happen.

Arthur Davidson – Denver Public Health Department – Director

What do you mean we're not giving guidance.

Yael Harris – Human Resources and Services Administration

So, we're saying there should be, but we…it's one…if you don't put it in something that ends up having to be certified, then there's no guarantee it'll happen. So if we're saying, well, the state could do it or the individual doctor could do it, that's allowing the capability to edit the system, but that's not meaning anyone's doing it and there may not be any CDS rule versus if we say it has to be, then it's part of the certification requirements.

Amy Zimmerman – Rhode Island Department of Health & Human Services

We're telling…the objective is the capability to receive or generate, we're saying to the doctor, you have to be able to receive or generate a specific recommendation. The doctor can generate a recommendation by looking at an individual schedule and come up with their own recommendation; you know what I'm saying. Like I'm still struggling, and maybe that's the way all of the NMPR for Stage 2 is and it didn't hit me until now, in this example. But, we're saying we want the doctor to use a computer-generated recommendation, right. And the way it's worded here, I mean, a physician can look at my history of all my immunizations and come up with their own recommendation, they do that every day. So the question…I think that we want the capability is not for the physician to receive or generate, it's for the EHR and we want the physician to use it. So, I've got two…I'm still struggling with two different issues here. There's that issue and then there's how do we deal with the receive or generate from the EHR.

Arthur Davidson – Denver Public Health Department – Director

So I guess one of the things is that, to be parallel with the previous measure, we probably need to say for what percent of the patients did this CDS run.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Yeah, I think we need something to measure it with.

Arthur Davidson – Denver Public Health Department – Director
Okay, okay, I hear you…

Amy Zimmerman – Rhode Island Department of Health & Human Services
What we're trying to do is get physicians to use the EHR proper…I mean, my understanding of meaningful use after all this time is that if this is about functionality we want the docs to use, and because they have to use it, then the functionality has to be built in. I don't think we want to be determining what the functionality is of the EHR without putting the docs on the hook for using it.

Arthur Davidson – Denver Public Health Department – Director
Right. Does that help you Yael?

Amy Zimmerman – Rhode Island Department of Health & Human Services
I mean…

Yael Harris – Human Resources and Services Administration
Yeah, that sounds great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
The practitioner uses EPs or whatever, uses…I don't know which recommendations you guys are going to settle on, to administer immunizations for X percent of the patient population or their patients if they're children. But…

Arthur Davidson – Denver Public Health Department – Director
Well I think that we…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
…whatever the recommendations are, then, there's clinical decision support that's going to have to support that, right.

Arthur Davidson – Denver Public Health Department – Director
Right. I don't know that we have to say which recommendation, it's just that…because it could be the national, the ACIP, could be as Amy said, a state or it could be something local. But, it could be any of those, but at least it has run at the time that a shot was being given or at least at the time that shots were given.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Well, I would…in anticipation of giving a shot.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yeah, because you'll send reminders out ahead of time, right, all that.

Amy Zimmerman – Rhode Island Department of Health & Human Services
I think we can even be more generic, we want the immunization recommendations, electronic generated immunization due recommendations to be used…

Arthur Davidson – Denver Public Health Department – Director
Right, in anticipation for giving an immunization.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Right.

Arthur Davidson – Denver Public Health Department – Director

Right, okay. I think this is helpful; this discussion will get this more crisp. I'll rework this one, these were good comments that you've added here. But, it's now getting to be, I think this must be worded as a CDS, it's getting hard to dance around using that word, or those words. So, I think that we'll have to include that phrase and, I don't know if Yael you still have concerns about using that, we are a little more specific here than we were, at least from the conversation if I incorporate the items that you all recommended, I think we'll be a little more specific.

Yael Harris – Human Resources and Services Administration

I think so; I think this better addresses it.

Arthur Davidson – Denver Public Health Department – Director

Okay, great. Any other comments on this one? We should move on to the next. I think the others will probably…hopefully go a little faster. We have about 45 minutes left. We'll move on to number two. So, this one…this is the electronic data on reportable lab results for the hospital and we made no change in that, but now we've added to this one the new objective for eligible providers to receive...so, this was broken apart. I can't remember whether it was this group that said break it apart…I believe it was this group that said break it apart into two separate ones, which is the ability to receive external data or case reporting from some knowledge base. So, that would be what the tables that CSDE has developed for reporting, would be available for the EHR to consume from a site. And I spoke with Seth and indeed the CDC doesn't have that running now, but that's something that CSDE and CDC thought that might be possible to get running, if someone would assume that responsibility for allowing EHRs to check this. Any concerns about this?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What, this is the reportable…

Arthur Davidson – Denver Public Health Department – Director

These are reportable conditions, yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, all right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, my comment is going to go across all of these, and again, if this is the way all of Stage 2 was written, then maybe it's sort of another comment, but, are we asking the doctor to have the capability to receive external data or again, or we're asking them to be able to obtain it and use it?

Arthur Davidson – Denver Public Health Department – Director

The EHR needs to incorporate it. The next one will say, they'll use it. So, this is…

Amy Zimmerman – Rhode Island Department of Health & Human Services

But is that just for the EHRs or the objectives for the hospitals and the doctors. This is my basic concern with how we've got these written.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and I think you're right, I think the first one you have is probably the certification criteria and then the second one you have is the real objective.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So I don't know if you need the first one, I think that she's exactly right. Because the first one, of course, since I'm a vendor, I'm reading that way, right…

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm trying to say, if I'm a doctor and I'm trying to meet these criteria, how am I going to have the capability to…I don't know, maybe it's too fine a point, maybe I'm sort of just…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

No, you're fine. I think it's the second one is the objective we want to bring to the table and then the certification criteria is the first one. This is…I just need to say from the vendor perspective, there's a lot…I don't…as we kind of decide, the challenge I see here is that this reportable disease stuff, well, I don't disagree that there's a huge gap, but it varies. Locally there's a lot of variation here too, so, maybe that's being standardized, but it makes sense that it is an externally generated table that the vendors can import.

Arthur Davidson – Denver Public Health Department – Director

So are you now saying Charlene, and Amy, that we should combine these again? I think they broke apart before, but now put more of the first one in the certification criteria that this…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I don't think you need the first one is kind of…I would say it's the second one that we…

Arthur Davidson – Denver Public Health Department – Director

Any comments from others?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm trying to think if we talked about splitting them, so we're not becoming schizophrenic here and driving you crazy Art. But, I do see…yeah, to me the first one is much more about the how to implement the second one.

Yael Harris – Human Resources and Services Administration

I agree and…

Amy Zimmerman – Rhode Island Department of Health & Human Services

And so therefore, it's more about the EHR as opposed to what the doctor does; and I thought that these objectives are physician and hospital objectives. So, unless we just…if we want to keep them separate, we can just…I would say…well we could say use. Well, we have use down below. Yeah, I mean I think the first one is more sort of…I would agree with Charlene, is more around the certification criteria.

Arthur Davidson – Denver Public Health Department – Director

Okay. That's helpful. So I'm going to go ahead and merge these two together and put most of the content that's in the first one under the certification criteria in the second.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yes.

Yael Harris – Human Resources and Services Administration

One way to merge it would be capability to accept and utilize.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, that's a good one. That's a great idea.

Arthur Davidson – Denver Public Health Department – Director

I think if I go back to an earlier version, we may have had it that way before…well, not necessarily the same words, but I think this was one at one time. So, but I'm happy that we're coming back to bringing these together.

Yael Harris – Human Resources and Services Administration

We just want to make you work harder Art, sorry.

Arthur Davidson – Denver Public Health Department – Director

We're doing well, we're doing well. So, any more discussion around that, I think we can easily put those two together.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, is it just that one criterion, the test that if it's…are there stan…for reportable diseases, or reportable conditions, is there work being done to make that accessible via a knowledge base in a standard way, is that happening?

Arthur Davidson – Denver Public Health Department – Director

Yes, so the CDC and CSDE are in…they've been working on this, this is the work of the Dwyer tables and revisions to…it's now called the Reportable Case something Table. I can't remember the exact name. They have that and at a meeting at CSD with CDC, there was a discussion about who would host this, and how this could be made accessible electronically. And Jim Buehler was at that meeting, who's the head of the Surveillance Group, and I believe he said, and Seth was in the room also, that there would be interest in trying to help make this available electronically. Whether CSD maintains that or CDC, that's still being discussed, but there was interest in trying to make this available. Is that good enough Charlene, or do you think that's not good enough yet.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I mean, I just think that has to be stated in your assumptions or in your…the intent of this is to blah, blah, blah, blah, blah, it assumes that blah, blah, blah, blah, blah is in place, because it's just, I think…again the challenge here is being able to handcraft every single local condition to be able to have to do this. And that's not what you want out there either.

Arthur Davidson – Denver Public Health Department – Director

No, but the locals could post to this site there…I hear what you're saying, that we do need to have this assumption that this has been created in our discussion. We'll put that in there.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, thank you.

Arthur Davidson – Denver Public Health Department – Director

Yeah, thank you. Good. Any other comments about this one? Okay. We'll move on to three. Syndromic surveillance. This one I think will not take us too much time. We're…let's see. We have no change to the eligible hospitals and we have no real push to do this with eligible providers yet, so, I think we're not likely to be working on syndromic surveillance for EPs. Any comments about that? Good. Move on to four. This one was about the state cancer registry and I don't know if I shared with you, I had a version once where I merged this cancer registry with the next one, and now I've broken it apart again based on recommendations from Seth over the last couple of days. So, and now it talks about mandated versus the next one, number five is other than mandated registries. So this mandated registry could be cancer, but some practices will not have cancer and there might be early hearing detection intervention, but that…hopefully, I believe it's mandated in all states. Maybe, Yael knows for sure…

Yael Harris – Human Resources and Services Administration

I don't know if it's mandated, but there's a capability to collect all that data in every single state.

Arthur Davidson – Denver Public Health Department – Director

Right.

Yael Harris – Human Resources and Services Administration

Every hospital can actually collect and report that data.

Arthur Davidson – Denver Public Health Department – Director

Right. Now, number four is about a mandated registry reporting.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And this is both for EPs and hospitals?

Arthur Davidson – Denver Public Health Department – Director

Yes, that they have an obligation, both of them have this obligation, yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What's it mean in addition to prior requirements for immunization? What does that mean?

Arthur Davidson – Denver Public Health Department – Director

So, this was…someone…I think it was…I can't remember if it was Seth, who said, I don't want people thinking that a mandated jurisdictional registry is immunizations, and therefore I've achieved this by doing the first, the second, yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I have a…just in terms of wording it, we may want to say, in addition to immunization registry, you know, blah, blah, blah, this is required. But, I lost you Art, because I thought you said we had them as one and we split them out, but here you're saying one of any kind of registry is mandated or if it's mandated in the state?

Arthur Davidson – Denver Public Health Department – Director

It's every provider is responsible for reporting cancer. That's mandated. But, and we don't have that…

Amy Zimmerman – Rhode Island Department of Health & Human Services

Is that true that every provider is responsible for…there's mandated reporting in every state for every provider on a cancer case?

Arthur Davidson – Denver Public Health Department – Director

I believe so. That's what Seth told me.

Yael Harris – Human Resources and Services Administration

That's what was proposed for Stage 2.

Arthur Davidson – Denver Public Health Department – Director

No, but that's…no this is independent of meaningful use. Cancer reporting is a mandate…

Amy Zimmerman – Rhode Island Department of Health & Human Services

So cancer is a reportable disease.

Arthur Davidson – Denver Public Health Department – Director

It is, yes.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So that would follow back, you've got that table of reportable conditions…

Arthur Davidson – Denver Public Health Department – Director

Okay, that's a different thing. So, let me just explain. There are reportable conditions and diseases of the communicable nature, and then there's also a separate, I believe it's a separate state law that all states need to maintain a cancer registry and under that state statute, providers are required to report cancer cases. It's separate from that Dwyer table that I was talking about for communicable diseases.

Amy Zimmerman – Rhode Island Department of Health & Human Services

All right, I didn't realize that all providers were required to report.

Arthur Davidson – Denver Public Health Department – Director

It doesn't mean they do it.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I just didn't realize there was a mandate on that.

Arthur Davidson – Denver Public Health Department – Director

Well, that's what Seth is telling me, is that cancer is required. So, maybe we can check on that.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, maybe every state's required to have a registry, but is every state…is every provider required…every provider in every state. All right, we can check on that. That just surprised me. But I could be very wrong.

Arthur Davidson – Denver Public Health Department – Director

I will check that.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I don't know about the cancer registry enough to know or have never worked with them enough to know if that's the case.

Arthur Davidson – Denver Public Health Department – Director

\Right. I'll check.

Amy Zimmerman – Rhode Island Department of Health & Human Services

All right, but going back to the way this is worded, so are you…so is this one that we're talking about just cancer, because you've got a mandated jurisdictional registry, you didn't have the word cancer in there again, and I thought…

Arthur Davidson – Denver Public Health Department – Director

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

…you've got other examples.

Arthur Davidson – Denver Public Health Department – Director

Right, because in some practices, cancer will be non-existent, so we were looking for something that would be of value to, for instance, pediatric practice may see almost no cancer in a year, but they see a lot of kids and they might have a lot of opportunity to report early hearing detection and intervention.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right, but it's the use of your term mandated because they may not have a mandated…in the state it may not be mandated or in their locale that they have to report to…on children with special healthcare needs, there may not be birth defects registry or if there is, it may be voluntary and not mandated. I'm struck with the word mandated here, if you're not going to just apply it to cancer, if that's really true about cancer, because, I don't know that these other…I think there's variation in the states about what other registries are there, and whether they're voluntary or mandated, and I think that's subject to state law.

Arthur Davidson – Denver Public Health Department – Director

So, in the exclusion, it could say where local or state health departments are incapable or have no mandate. Right, isn't that what you're asking Amy?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, and I'm also…yes. Yeah, I mean if there's no mandated registries that may get a bye on this one or are we saying that we want them to send to at least one registry in their state, whether it's mandated or not.

Arthur Davidson – Denver Public Health Department – Director

No, the next one deals with the not mandated. This one is about mandated.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, so this is about mandated reporting to registries other than immunization, if your state has one.

Arthur Davidson – Denver Public Health Department – Director

That's correct. Any further concern about this? I know I have to a bunch of re-wording on this, based on our conversation. So, Seth was saying that we should not conflate mandated and non-mandated registry reporting and that's why this…at one time, and I can't remember if I sent out a version where these were combined…I had this and the next one in the same. Actually, it was nothing in the next one, it just said you needed to report two and any two that you wanted and Seth said, they'll be a lot of pushback from the cancer group if you don't keep one in here for mandated reporting, especially since in Stage 2, cancer is already likely to be in there. Just that we were thinking, so this pediatric practice with no cancer cases, or very few cancer cases, is really not getting much benefit and it's not contributing much to any population or public health measures when it doesn't really apply to them. But there are other things that might be applicable or valuable to them.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And so what you…just in terms of rewording, a suggestion, and I don't know if this is helpful or not, might be to say, capability to participate and set standardized reports to mandated…to cancer registry, if you have, put in some criteria…caseload or if you have sufficient cases. In the event that you don't, then you could substitute. I mean, maybe that's too wordy for an objective, but to me, the way it's worded here is just really confusing.

Arthur Davidson – Denver Public Health Department – Director

So that…

Amy Zimmerman – Rhode Island Department of Health & Human Services

It still doesn't drive, if we've got cancer in Stage 2, it doesn't necessarily address or even drive cancer.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Again why is…I guess the concept that you really would like is to be more flexible and more wider to different types of registries that exist for different purposes, that makes a lot of sense. That making a lot of sense also makes it challenging because it becomes much less defined. So, is there a need to expand it to beyond cancer at this point, or…it's just going to be a really hard one. I think you're going to get lots of pushback because it's not…there's too much variability, that kind of stuff.

Arthur Davidson – Denver Public Health Department – Director

Well, the early hearing detection and intervention has an HL7 balloted and approved standard. So, we were just trying to include another one that was far along. It's turned out that cancer got in there and really made a strong case and our committee was not really that strong on the cancer registry and they got it built into Stage 2, the NPRM. So, we're just now trying to catch up and say, if there's an accepted standard, as there is for the EHCI, we would let that be also used in this mandated section. It may be too hard and more complex than we'd like to be proposing, but we have a description of this in the discussion. I don't know that we want to put that into the objectives.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And then my other question is, is this only for…we're saying to a mandated, so all we're asking them to do is electronically send to one mandated, non-immunization registry in their state or jurisdiction.

Arthur Davidson – Denver Public Health Department – Director

That's correct. Let me work on this, and see if I can get…and this has been a good discussion, it's maybe not as clear as it could be.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah and I think the other…

Amy Zimmerman – Rhode Island Department of Health & Human Services

When you start reading the discussion it gets clearer, but I'm thinking about ultimately what gets promulgated or…yes, and in the NMPRs and in the final rule there is discussion, but, people try to go with…you want to make the objective and measures as clear as possible, standing on their own without too much complexity.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right. Another thing is, you look at the measure itself, I know attestation of submission of 80% kind of…you either have attestation or you have measure of 80% right, do you need both? And, is 80% a little high, or…to get going on this one. I don't know what the cancer registry attestation level was in that one. Let me look. I forgot.

Arthur Davidson – Denver Public Health Department – Director

Well, was it up there, no, we don't have the criteria in…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

(indiscernible), right.

Arthur Davidson – Denver Public Health Department – Director

It was what?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It's ongoing…and I'm sure there was a lot of comment about what do you mean by successful ongoing…so, why would you change it like from 80% rather than ongoing submission. I don't know; we don't know what Stage 2's going to do anyway, so…

Arthur Davidson – Denver Public Health Department – Director

Right, we don't know that. And I don't know. What does ongoing submission mean?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, exactly…

Arthur Davidson – Denver Public Health Department – Director

How would we know if it's…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm sure there was a lot of comment that came in on that.

Michelle Nelson- Office of the National Coordinator

This is Michelle, there was a lot of comment on that, especially in the IE Workgroup, and actually, Seth Foldy gave a lot of feedback on what that actually meant. The IE Workgroup did give a recommendation that I don't believe the Health IT Policy Committee accepted in their comments. So.

Arthur Davidson – Denver Public Health Department – Director

And what was that…

Michelle Nelson- Office of the National Coordinator

But they did ask for it to at least be defined. Well, they had put a percentage to it and so, I'm just going off the top of my memory, but, the ME Workgroup declined to put in the piece about the percentage, but they did put in the fact that it does need to be defined. So, hopefully within part of the final rule, it will be defined.

Arthur Davidson – Denver Public Health Department – Director

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So I'm trying to figure out from what was recommended from the Stage 2 NMPR, our Stage 3 recommendation. We're just broadening it to say if you don't have cancer cases, you're required to do another mandated registry if there is one, is that…am I missing something?

Arthur Davidson – Denver Public Health Department – Director

Exactly, exactly.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And you know, and when you present it, I think if you say that's like what Paul likes to hear, that's the delta here, and the more you can keep it the same as the other ones below, the easier we'll get through it, so the delta is, the addition of other mandated registries to cancer.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, but this isn't in addition to, this is in lieu of, if you don't have sufficient cancer cases, however that's defined.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah,

Arthur Davidson – Denver Public Health Department – Director

Correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well framing it that way helped me get through this, so, sorry it took me so long to…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We've got you now.

Arthur Davidson – Denver Public Health Department – Director

Okay, well it's helpful for me to hear that, so that I can frame this better for us to present next week.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Arthur Davidson – Denver Public Health Department – Director

Okay. So, I think we can move on to number five. So this one is not a mandated registry, it is, as was defined in the current NPRM, as a specialized registry, and here, this was one where we proposed that someone can use either a jurisdictional, so if the jurisdiction has a specialized registry, or a professional registry, something that we heard testimony from many of the specialty societies that there would be a registry like American Heart…American Cardiology Association or Thoracic Society, they have registries. So, this is where they…this is a non-mandated registry. And again, it says in addition to any prior mandated registry requirements. And it doesn't really say where the registry lives, it could be at the jurisdiction, it could be professional society, could be at the HIE, it could be at an ACO.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Arthur Davidson – Denver Public Health Department – Director

And I don't know that we…I mean it says…I mean we could use the word ongoing submission, I don't know whether it's…if this is something that we should have attestation or, if we say ongoing submission, that needs to be defined as well, or how you would measure that. That's the same problem that Michelle commented on from the Meaningful Use's Workgroup assessment from the IE Workgroup.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'll weigh in, I mean, at the end of the day, because the gap is actually doing the reporting, I do like having some threshold of those patients that qualify are actually…and we could…you could put a 10 or 20%, because once the capability's there, then it'll happen. The problem now is, whether it's reportable conditions or these registries, it's like a lot of work to get each one in place. So similarly, like kind of what we're struggling with in Care Coordination, this kind of has to be like a roadmap of this. And my concern on the whole section is, how to do all this at the same time, if you will. But, I like the concept of actually making the measure around a percentage who has…of those patients who have been submitted and I don't think it has to be high.

Arthur Davidson – Denver Public Health Department – Director

Yeah, okay. I just put down a number and we certainly could change this back to 20%.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I would just because once there, you got it…

Arthur Davidson – Denver Public Health Department – Director

Yeah. I'm sorry, go ahead Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Everyone…then there's exclusions, all those things, you're not (indiscernible).

Arthur Davidson – Denver Public Health Department – Director

Any other comments about this one? Amy or Yael?

Yael Harris – Human Resources and Services Administration

None from me.

Amy Zimmerman – Rhode Island Department of Health & Human Services

No.

Arthur Davidson – Denver Public Health Department – Director

Okay. So this is number five. We'll move on, a fair amount of discussion that we have in here as well. And feel free if anybody does read through this and wants to send me some comments, I'll be happy to incorporate them before our meeting next week. We have about fifteen minutes and I think we're going to have time for public comment; we shouldn't be too much longer. The next one, number six is just a discussion; we're really not adding anything here. There was the earlier Meaningful Use Workgroup comment that patient generated data should be submitted to public health agencies, and we just described how that would happen if we were to increase the demographic variables as we proposed to the Meaningful Use Workgroup, to include occupation and industry, and that would then be available in those case reports that are described I think in number four. No, must be number three, for hospitals and eligible providers. And that would add a significant public health value and also population health value, as we could identify health disparities, conditions that occupations might be at risk for.

Amy Zimmerman – Rhode Island Department of Health & Human Services

All right, so I'm sorry, I had to reboot up my computer. So, we don't have an objective on this.

Arthur Davidson – Denver Public Health Department – Director

That's correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

Arthur Davidson – Denver Public Health Department – Director

The main thing is that it's already been incorporated in an objective under demographics for the first group…the first…

Amy Zimmerman – Rhode Island Department of Health & Human Services

We're just saying we're supporting it.

Arthur Davidson – Denver Public Health Department – Director

Yes, we're supporting it. Correct. So, if there are no comments on that, I think we can move on to number seven. So, this is a new objective for hospitals and this is about healthcare associated infection. This was the presentation from David Lawrence from Washington State, where the reports go to the National Healthcare Safety Network, and that's going on now for several hundred hospitals and many other facilities, I think mostly dialysis centers. And for many hospitals already, they're required to do something like this for JCAHO, whether they're reporting to this network or not is something that we're trying to encourage through this additional objective.

Amy Zimmerman – Rhode Island Department of Health & Human Services

It seems fine to me.

Arthur Davidson – Denver Public Health Department – Director

Seems fine. Any comments Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Um, again I think it's back to the kind of…occupation…again, it's just in terms of that measure, it's just like…

W

Just starting at 80% is high, is that what your concern is Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

High and then it's just…you're kind of…whatever the…you know, at the end of the day, it's that the reporting is done for a percentage of the patients, right. So that seems to be the simplest measure, because we can count. Now, you want to know that it's received, but it really is that the percentage of those patients are actually…the reports are actually sent, right. And you can lower the percentage I think.

Arthur Davidson – Denver Public Health Department – Director

We can lower the percent, yes, I put it…I'll just change it to 20, just to say that…so, it's the total…the hospitals need to track on the HAI, I think that's a requirement for JCAHO. Now the question is, do they report it or not. And this reporting would go to this centralized system at CDC. And they're currently doing this on a web page system, and instead of this web-based entry, the EHR would produce a CDA, which is what the presentation by David Lawrence suggested, that a CDA be used to send that information.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So is this like for each patient with a hospital-acquired infection? Is it a patient specific thing?

Arthur Davidson – Denver Public Health Department – Director

It's event specific. So, the patient could have two events…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, you could have two events. Okay. Or cases, as opposed to…

Arthur Davidson – Denver Public Health Department – Director

Right, case reports. Correct.

George Hripcsak – Columbia University

Art, this is George.

Arthur Davidson – Denver Public Health Department – Director

Yes George.

George Hripcsak – Columbia University

Is the purpose of centralizing it to track infections in the community or to monitor the relative safety of…the safety behaviors of the organization. In other words, is this a safety effort or is this an infectious disease effort.

Arthur Davidson – Denver Public Health Department – Director

This is a bit of both. I don't think that it's one or the other. The hospitals that do report can receive their data back and, I think they provide reports that allow infection control practitioners to maybe change behaviors.

Marty Fattig – Nemaha County Hospital (NCHNET)

Hey Art.

Arthur Davidson – Denver Public Health Department – Director

Yes Marty.

Marty Fattig – Nemaha County Hospital (NCHNET)

Yeah, this is Marty. What's happening in hospitals, especially PPS hospitals, is they're going to base payment on adverse drug events….I'm sorry, on hospital-acquired infections and they're going to reduce your payment if you have an exceptionally high level of hospital-acquired infection. So, this is one of the never events that you're not…that they're going to say, if this happens, we're not paying for it. So, that's…we're having to report these now.

George Hripcsak – Columbia University

So, at what point are we…I'm sorry about this, because I came in about 11, I'm sorry I came in…I had to leave and come back. Is this a quality measure in so far as measuring the quality of the organization or is this a public health function in which case we really want to see what infections are occurring in the community, I guess that's why I asked my question. And so, does this go under the Quality Measure Group in some way, because this is a quality measure, we can just stick in and have every hospital do?

Arthur Davidson – Denver Public Health Department – Director

Well, I guess that's a question. Should this be a quality measure, that's one thing, but I think this is an effort by the public health community to keep track of the risk in hospitals as much as it is about improving the quality in the institution. It's serving both of those functions George.

George Hripcsak – Columbia University

Okay, well in so far as it does that second one, then it could belong in public health. That's what I'm saying.

Arthur Davidson – Denver Public Health Department – Director

Okay.

Marty Fattig – Nemaha County Hospital (NCHNET)

This is Marty. Where I see this being valuable to public health is…essentially like MRSA, which essentially originated in healthcare institutions and pretty soon it became a public health issue, and I think this could be warning public health about what's coming down the pike.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, that's a good point.

George Hripcsak – Columbia University

Okay.

Arthur Davidson – Denver Public Health Department – Director

Okay. So, I changed the measure to 20% Charlene, does that sound good?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But, how do I count a case though, how do I know…we'll have to have provisions to count these hospital-acquired infections…

Arthur Davidson – Denver Public Health Department – Director

But I think what Marty said was that that is happening already.

Amy Zimmerman – Rhode Island Department of Health & Human Services

But is there a designation in my EHR that I know there's one, is there a code for hospital-acquired infections?

Marty Fattig – Nemaha County Hospital (NCHNET)

There will be, ICD-10. And I think yeah, we're going to be able to find some way to get you a denominator.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, so I need to know how to count one so I know that for each one I've submitted my report.

Marty Fattig – Nemaha County Hospital (NCHNET)

Right, currently we're just submitting them as they occur and so it's numbers based on admissions generally. You know, it's a percentage based on admissions is what we're looking at as the quality standard.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Art, there may be stuff out there that will help to identify one in the system, I'm not sure systems are organized that way, per se.

Arthur Davidson – Denver Public Health Department – Director

How systems are organized to identify them?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, how do we tag a hospital-acquired infection? We've got to kind of do them for…from a system, you identify them, there's a code, I'm sure, and that we pull for measurement.

Arthur Davidson – Denver Public Health Department – Director

Right, so we may need to…I might be able to drop David a note to ask him how this is going to happen. It's interesting that ICD-10 would actually be a way to do that, so, as it occurs, the ICD-10 is actually capturing the HAI, whereas 9 probably doesn't do anything near that now. Is that right Marty?

Marty Fattig – Nemaha County Hospital (NCHNET)

That's right, nine's not granular enough yet.

Arthur Davidson – Denver Public Health Department – Director

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So Art, this may be an area where you need an assumption to say, the assumption is that there's a way to tag these events.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, exactly.

Amy Zimmerman – Rhode Island Department of Health & Human Services

The other thing is, in general comments for a lot of these, as I'm sitting here listening to the conversation, I mean, I appreciate the need to sort of drop the percentage. But then again, if it's required and people are getting payment on it, to me it's sort of moot what the percentage is because you really should be doing it and have to do it on all. So, it gets into this lack of definition of ongoing submission, but do we really want to say we're willing to settle for 20%. So, but that applies to a bunch of these, so I don't know if that's sort of just a general comment. Like, we really have to figure out where it makes sense to put percentages on things that are mandated. Technically if they're mandated, why are we saying it's okay to…well, we're saying it's okay to only do it electronically 20% of the time, you could do the rest of it some other way, I guess.

Arthur Davidson – Denver Public Health Department – Director

Right. Yup.

Marty Fattig – Nemaha County Hospital (NCHNET)

This is Marty. I will assure you that any abstracter who is getting this data manually, once they have the ability to have the EHR give them the data, and actually download it to the place it needs to go, it's going to be 100%, they're not going to do it any other way.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm not sure if we really need a low threshold versus another way of saying, ongoing…but we all know that the ongoing submission is so ill defined that that upsets people too, in terms of lack of clarity. So, I don't have an answer yet for that.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Arthur Davidson – Denver Public Health Department – Director

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, we, I think, are aligned at whatever that wording comes out, we probably can align under or improve…I think the intent's all the same here.

Arthur Davidson – Denver Public Health Department – Director

Um hum.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Providing the provision and once it's there, then it will happen.

Arthur Davidson – Denver Public Health Department – Director

Okay. Any more comments about seven. We have a minute here to talk about number eight, and we're just going to open the lines. So this one was about vaccine adverse event reporting, but then with Seth, he said it shouldn't just be vaccines, it could be to any one of these other sites, you know, FDA has sites for vaccines, it has a site for reporting device problems, drugs or other biologics, so, we broadened this out based on conversation with Seth. And. I don't know whether we think this…this was something that was presented to us, and looking to see whether the group still feels that this should be something for us to add in.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is Charlene. I actually support this. There's even pressure, for instance, as adverse events occur, if they are generated because you're using an EHR, there's pressure to have standards in terms of that reporting and I'm afraid these standards are going to get all over the place rather than be focused kind of in a consolidated way. So, again, I think it's a challenge to be able to do this with some focus, in terms of really being able to do this will help the whole community. So, I don't know how feasible it is certainly, but I think it makes a lot of sense and it's a huge start in terms of patient safety.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I'm fine leaving it in and I think the larger group can decide if we have too many and decide what they want to take out. The one comment I have here is on this one as a measure we have all adverse events as opposed to all hospital-acquired infections and all mandated reporting previously. So again, I think we're very inconsistent in our measurements.

Arthur Davidson – Denver Public Health Department – Director

So, it says all, okay, I'll eliminate the all.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well, we don't have any measurement then either. We need…I'm just making the point that for hospital…just to me I see just like hospital acquired infections, this one, and even on the mandated registry, if it's mandated, we shouldn't be saying we're accepting 20%, right? So, I don't know how to finesse that, but I'm saying I think for those three, we should at least be standard in our approach of measurement.

Arthur Davidson – Denver Public Health Department – Director

Okay, thank you.

Amy Zimmerman – Rhode Island Department of Health & Human Services

If we want to say all, then say all, but do it to all three, because I think the same concept applies to all three. If we want to say a percent, which kind of is meaningless…whatever. But…

Arthur Davidson – Denver Public Health Department – Director

Well, that's probably where Seth's going to come back and the recommendation was ongoing submission, probably means all.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, it does. The problem with ongoing submission means, okay, from what point on, what happens if there's a break in electronic…people, at least on my end, when it came to ongoing submission around immunizations, there were all sorts of questions about better definition. I'm okay with ongoing submission, as long as there's some definition behind it.

Arthur Davidson – Denver Public Health Department – Director

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Meaning, once you start it, you're doing it all the time for everything. But people were getting really…individuals that gave to implement were getting kind of really hung up about…okay, so the system goes down, and what happens…does that mean I violated it. Well, I mean, I think the intention is all the same here and the intention is, systems are going to fail, for some period of time you're going to have to go back and capture that data and resubmit it one way or another, right.

Arthur Davidson – Denver Public Health Department – Director

Any further comment? I know this is a bit ambiguous still, and maybe the workgroup can help us define some of it, when we present it next week. Any other comments about this one?

Marty Fattig – Nemaha County Hospital (NCHNET)

Art, this is Marty. This is going to be really tough to do unless there's a person involved. I mean, to do this automatically, I mean you're going to have to somewhere identify an adverse event and then some person be involved in submitting it electronically.

Arthur Davidson – Denver Public Health Department – Director

So, do you know if ICD-10 would cover these adverse events?

Marty Fattig – Nemaha County Hospital (NCHNET)

I do not believe so. It would cover some, but not all.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, so how do we know them is our issue. And then like, so if there's an adverse event and you do your root cause analysis, right, and all that stuff…

Marty Fattig – Nemaha County Hospital (NCHNET)

Yup, yup.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…determine that it was your electronic health record or it was a dog bites in your ED or whatever it is, it's like…I don't know how we tag those things either.

Marty Fattig – Nemaha County Hospital (NCHNET)

That's the problem. It definitely needs to happen, but…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And then the data that you collect for each one is variable, right.

Marty Fattig – Nemaha County Hospital (NCHNET)

Absolutely.

Arthur Davidson – Denver Public Health Department – Director

So is this not ready.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, I think we should discuss it, because I think it's important to put it at the policy level. I think some standards should be investigated around it, right.

Arthur Davidson – Denver Public Health Department – Director

Right.

Marty Fattig – Nemaha County Hospital (NCHNET)

Right, I agree Charlene, I think that we should leave it here as a marker, knowing that it's going to require some work, but the system may catch up to us by then.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and this is a really important one in my view.

George Hripcsak – Columbia University

I think we need to put in a viable objective and measure.

Arthur Davidson – Denver Public Health Department – Director

So, it could be that the user has to push a button to submit an adverse report, so it's not automatically triggered, and we get in trouble when we say capability, because there may not be one, so we can't ensure one, and we get in trouble when we say test…so I'm not sure how to do the measure.

Marty Fattig – Nemaha County Hospital (NCHNET)

Twenty percent, we're not going to…no one's going to know what 20% of their adverse event report…potential reports would have been. I don't know if we can do capability. I guess capability…yes, it's hard. But it think you have to…I think having to hit a button to send it in is fine, if we're worried about how we're going to find it automatically.

Arthur Davidson – Denver Public Health Department – Director

So, one idea was that we did have testimony about the CDISC message and whether that's…the EHR should be using this method to, when you hit the button, CDISC retrieves the form that allows you to enter the information and that is…sent on, whatever needs to happen, but, that was a method. That's the how that we heard from Becky Kush. I don't know what…

Marty Fattig – Nemaha County Hospital (NCHNET)

Well, if…right, it's just a template, I mean, it's the send report to FDA button, then you get an FDA form

and then whatever standards the Standards Committee comes up with, is fine by us.

Arthur Davidson – Denver Public Health Department – Director

And then what's the measure, since we don't know how many will occur. I don't think 10% or 20%, unless we just say capability. But we have to say something. So, attestation…

Marty Fattig – Nemaha County Hospital (NCHNET)

Not to mention how to get it to the FDA.

Arthur Davidson – Denver Public Health Department – Director

Well, that would be…the EHR is capable, once the form is completed, of pushing it to the FDA.

Marty Fattig – Nemaha County Hospital (NCHNET)

No, I know, that one I just meant the FDA side of it.

Arthur Davidson – Denver Public Health Department – Director

So you want attestation that it's possible and a count of how many you did…

Marty Fattig – Nemaha County Hospital (NCHNET)

Right.

Arthur Davidson – Denver Public Health Department – Director

…with no threshold.

Marty Fattig – Nemaha County Hospital (NCHNET)

That's correct.

M

I guess that's capability. Okay, I guess that's what we have then. What we don't want is a topic for discussion. We want an objective and a measure and I guess this is it.

Arthur Davidson – Denver Public Health Department – Director

Okay, so everybody's saying we need to make sure that our measures are crisp, they're not quite crisp enough yet, and we need to do some work over the next couple of days. Not necessarily on this one, but on the earlier ones we discussed. I get this…and that goes back to Paul's original comment about this document.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So Art, this is Amy. And just so you know, I'm not going…the next call is on Wednesday, right.

Arthur Davidson – Denver Public Health Department – Director

It is Wednesday, I'm not sure what time it is, I'm on the West Coast now and…

MacKenzie Robertson – Office of the National Coordinator

It's set…this is MacKenzie, it's 9 a.m.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, so, I'm just going to let you know that I'm unfortunately not going to be able to be on the call.

Arthur Davidson – Denver Public Health Department – Director

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And Art, I also just want to let you know that I was on the information…IE workgroup yesterday and they're also breaking down into subgroups on Stage 3, and they sort of broke into subgroups. And there's a population public health one and the decision was that we would just take what we've done in this workgroup, share it with that workgroup and let them, so that they're not starting from scratch. And it would just sort of weigh in and say, yay, nay or we would recommend changing it, so that the IE workgroup from any of these that apply to information exchange, that are related. And I'll do that…I mean, I'll facilitate that one meeting and conversation and call. So, just wanted to make sure you were aware of that.

Arthur Davidson – Denver Public Health Department – Director

So are you leading that subgroup?

Amy Zimmerman – Rhode Island Department of Health & Human Services
Yeah, I'm…but the subgroup is hopefully going to be one meeting IE, one call.

Arthur Davidson – Denver Public Health Department – Director
Okay, great. Thank you, thank you for letting us all know that. We're happy to have this be recycled and reviewed by another group.

Amy Zimmerman – Rhode Island Department of Health & Human Services
I mean, it was a starting point and then if they think of other ideas from and information exchange point of view, not all of these…they, whatever. But, I think this one's pretty clear since there is a fair bit of health information exchange here, at least in some of them on bidirectional stuff that we can use as just a starting point.

Arthur Davidson – Denver Public Health Department – Director
Great. Thank you.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Did I get that right Michelle?

Michelle Nelson- Office of the National Coordinator
You did, thanks Amy.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Okay.

Arthur Davidson – Denver Public Health Department – Director
So, we're over time and we probably should open this up for public comment. I will try to work on another draft, get it out to everybody through Michelle, and we'll be on the phone next week, at 9 o'clock Eastern time on Wednesday.

MacKenzie Robertson – Office of the National Coordinator
Okay, all right. This is MacKenzie. If you want to continue the call, we can stay on a little bit longer, or if you just want to take it offline, that's fine as well.

Arthur Davidson – Denver Public Health Department – Director
I think, unless there are other comments, burning comments…as I said, please feel free to send me any…if you look over this document and have anything you want to send me, do so in the next couple of days. I'll try to incorporate them before our next presentation. But I think we're probably ready to open the line for public comment.

MacKenzie Robertson – Office of the National Coordinator
Okay. Operator, can you please open the line for public comment.

Public Comment

Rebecca Armendariz – Altarum Institute
If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone you may press *1 at this time to be entered into the queue. We have no comments at this time.

Arthur Davidson – Denver Public Health Department – Director
Okay. Well thank you all for your thoughtful comments and hopefully next week this presentation can be shorter and more concise, and the Meaningful Use Workgroup will receive these recommendations without a lot of debate.

Yael Harris – Human Resources and Services Administration
Thanks for you leadership Art.

Arthur Davidson – Denver Public Health Department – Director
Thank you. Okay. Have a good weekend everybody.

W
You, too.

MacKenzie Robertson – Office of the National Coordinator
Thanks everyone.

Marty Fattig – Nemaha County Hospital (NCHNET)
Take care. Thanks Art.

Arthur Davidson – Denver Public Health Department – Director
Bye bye Marty.